Department of Medical Assistance Services
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https://dmas.virginia.gov

MEDICAID BULLETIN

Last Updated: 07/28/2022

Revisions to Medicaid Payments for Medicare Coinsurance, Copays, and Deductibles (Crossover Claims)—Effective July 5, 2019

DMAS is modifying the payment calculation for individuals eligible for both Medicare and Medicaid for remittances on or after July 5, 2019. Claims paid on or after July 5, 2019 will reflect Medicare's sequestration reduction when determining the amount of the Medicare coinsurance, copay or deductible that Medicaid pays.

Background on Medicaid Payment for Medicare Claims and Sequestration

"Crossover claims" refer to a Medicare claim that "crosses over" to fee-for-service Medicaid or to a Medicaid managed care plan for possible payment of Medicare coinsurance, copays, and deductibles for members eligible for both Medicare and Medicaid. DMAS crossover reimbursement policy is described in an October 28, 2003 Medicaid Memo when Medicare is the primary payer and Medicaid is secondary. For crossover claims, "the amount paid by Medicaid, in combination with the Medicare payment, will not exceed the amount Medicaid would pay for the service if it was billed directly to Medicaid."

The Federal Budget Control Act of 2011 required mandatory across-the-board reductions in Federal spending, also known as sequestration. President Obama issued a sequestration order on March 1, 2013, which is still in effect. In accordance with this order, Medicare claims with dates of service or dates of discharge on or after April 1, 2013, incur a 2% reduction in Medicare payment. In processing crossover claims after sequestration went into effect, DMAS did not account for the sequestration reduction when calculating the amount of the Medicare coinsurance, copay or deductible that Medicaid would pay.

Description of Medicaid Payment Change

Effective with remittances on or after July 5th, DMAS will account for the sequestration reduction when determining the amount of the Medicare coinsurance, copay or deductible that Medicaid would pay.

Impact to Providers and Managed Care Organizations

Many crossover claims result in no additional Medicaid payment. For those claims with additional Medicaid payment, this change will reduce Medicaid payments for crossover claims by the amount of the sequestration reduction. This change in claims payment will have no impact on claims with a paid date before July 5, 2019. Providers do not have to change their Medicare billing practices.

Medicaid MCOs in the Commonwealth Coordinated Care Plus (CCC Plus) program must implement this claims payment policy no later than July 1, 2019.

For questions regarding crossover reimbursement and sequestration, please contact the Medicaid Provider HELPLINE at 804-786-6273 or 800-552-8627 Monday-Friday 8:00AM to 5:00PM.

Medicaid Expansion

New adult coverage begins January 1, 2019. Providers will use the same web portal and enrollment verification processes in place today to verify Medicaid expansion coverage. In ARS, individuals eligible in the Medicaid expansion covered group will be shown as "MEDICAID EXP." If the individual is enrolled in managed care, the "MEDICAID EXP" segment will be shown as well as the managed care segment, "MED4" (Medallion 4.0), or "CCCP" (CCC Plus). Additional Medicaid expansion resources for providers can be found on the DMAS Medicaid Expansion webpage at: http://www.dmas.virginia.gov/#/medex.

PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal Automated Response System (ARS) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-forservice members.	https://dmas.kepro.com/
Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit:

	www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or call: 1-800-424-4046
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627